

Medical Assistance Administration



Physician-Related Services

Billing Instructions

[Chapter 388-531 WAC]

July 2004

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About this publication

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Important Contacts

A provider may contact MAA's toll-free lines for questions regarding MAA programs. However, MAA's response is based solely on the information provided to the representative at the time of the call or inquiry, and in no way exempts a provider from following the rules and regulations that govern MAA's programs. [WAC 388-502-0020(2)].

Where do I call for information on becoming a DSHS provider, submitting a change of address or ownership, or to ask questions about the status of a provider application?

Call Provider Enrollment toll-free at:
(866) 545-0544

Where do I send my claims?

Hard Copy Claims:
Division of Program Support
PO Box 9248
Olympia WA 98507-9248

Magnetic Tapes/Floppy Disks:
Division of Program Support
Claims Control
PO Box 45560
Olympia, WA 98504-5560

Where do I call/look if I have questions regarding...

Policy, payments, denials, or general questions regarding claims processing, or MAA Managed Care?

Provider Relations Unit
(800) 562-6188

<http://maa.dshs.wa.gov/provrel>

Private insurance or third-party liability, other than MAA Managed Care?

Coordination of Benefits Section
(800) 562-6136

Electronic Billing?

Electronic Media Claims Help Desk
(360) 725-1267

Internet Billing (Electronic Claims Submission)?

WinASAP

http://www.acs-gcro.com/WINASAP2003/Software_Download/software_download.html

All other HIPAA transactions

<https://wamedweb.acs-inc.com/wa/general/home.do>

To use HIPAA Transactions and/or WinASAP 2003 enroll with ACS EDI Gateway at 1 800 833 2051.

How do I obtain copies of billing instructions or numbered memoranda?

Check out our web site at:
<http://maa.dshs.wa.gov>

-or-

Check out the Department of Printing's web site at:

<http://www.prt.wa.gov/> (click on "General Store")

Other Important Numbers

Client Assistance/ Brokered Transportation Hotline (Clients Only)	1-800-562-3022
Disability Insurance	1-800-562-6074
Durable Medical Equipment (DME)/Prosthetics Authorization	1-800-292-8064
Fraud Hotline	1-800-562-6906
MAA Managed Care (Healthy Options) Enrollment.....	1-800-562-3022
Acute PM&R Authorization FAX	1-360-586-1471
Pharmacy Authorization (Providers Only).....	1-800-848-2842
Provider Inquiry Hotline (Providers Only)	1-800-562-6188
Provider Enrollment.....	1-866-545-0544
Telecommunications Device For The Deaf (TDD)	1-800-848-5429
Third-Party Resource Hotline	1-800-562-6136
TAKE CHARGE	1-800-770-4334

Provider Field Representatives

(360) 725-1024
(360) 725-1027
(360) 725-1022
(360) 725-1023

MAA Billing Instructions

Access to Baby & Child Dentistry
Acute Physical Medicine & Rehabilitation
Adult Day Health
Ambulatory Surgery Centers
Births in Birthing Centers
Blood Bank Services
Chemical Dependency
Chemical-Using Pregnant (CUP) Women
Childbirth Education
Chiropractic Services for Children
Dental Program
Direct Entry
Early Periodic Screening, Diagnosis &
Treatment (EPSDT)
Electronic Billing Manual
Family Planning Services
Federally Qualified Health Centers
First Steps Childcare
General Information Booklet
Ground/Air Ambulance Medical
Transportation
Healthy Options/Basic Health Plus/
Children's Health Insurance Program
Health Care Plans
Hearing Aids and Services
HIV/AIDS Case Management
Home Health Services
Home Infusion Therapy/Parenteral Nutrition
Hospice
Hospital Inpatient
Hospital Outpatient
Indian Health Services
Interpreter Services
Involuntary Treatment Act (ITA)
Transportation
Kidney Center Services
Long-Term Acute Care
Maternity Support Services/Infant Case
Management

Medical Nutrition Program
Medical Nutrition Therapy
Neurodevelopmental Centers
Nondurable Medical Supplies and
Equipment
Nursing Facilities
Occupational Therapy
Oxygen/Respiratory Therapy
Physical Therapy
Physician-Related Services
Planned Home Births
Prenatal Diagnosis Genetic Counseling
Prescription Drug Program
Private Duty Nursing Services
Prosthetic & Orthotic Devices
Psychologist
Rural Health Clinics
School Medical Services
Speech/Audiology Program
TAKE CHARGE
Vision Care Services
Wheelchairs, Durable Medical Equipment,
and Supplies

**For more information on MAA billing
instructions, call 1-800-562-6188.**

**These billing instructions are available
through MAA at:**

<http://maa.dshs.wa.gov>
(click on Provider Publications/Fee
Schedules)

or the Department of Printing at:

<http://www.prt.wa.gov/>
(click on "General Store")

Definitions

The sections defines terms and acronyms used in these billing instructions.

Acquisition cost (AC) – The cost of an item excluding shipping, handling, and any applicable taxes.

Acute care – Care provided for clients who are not medically stable or have not attained a satisfactory level of rehabilitation. These clients require frequent monitoring by a health care professional in order to maintain their health status.

Add-on procedure(s) – Secondary procedure(s) performed in addition to another procedure.

Admitting diagnosis – The medical condition responsible for a hospital admission, as defined by ICD-9-CM diagnostic code. [WAC 388-531-0050]

Assignment – A process in which a doctor or supplier agrees to accept the Medicare program's payment as payment in full, except for specific deductible and coinsurance amounts required of the patient.

Authorization – MAA official approval for action taken for, or on behalf of, an eligible Medical Assistance client. This approval is only valid if the client is eligible on the date of service.

Authorization number – A nine-digit number assigned by MAA that identifies individual requests for services or equipment. The same authorization number is used throughout the history of the request, whether it is approved, pending, or denied.

Base anesthesia units (BAU) – A number of anesthesia units assigned to a surgical procedure that includes the usual preoperative, intra-operative, and postoperative visits. This includes the administration of fluids and/or blood incident to the anesthesia care, and interpretation of noninvasive monitoring by the anesthesiologist.

Bundled services – Services integral to the major procedures that are included in the fee for the major procedure. Bundled services are not reimbursed separately.

By report (BR) – A method of reimbursement in which MAA determines the amount it will pay for a service that is not included in MAA's published fee schedules. MAA may request the provider to submit a "report" describing the nature, extent, time, effort, and/or equipment necessary to deliver the service.

Client – An applicant for, or recipient of, DSHS medical care programs.

Code of federal regulations (CFR) – A codification of the general and permanent rules published in the federal register by the executive departments and agencies of the federal government.

Community services office (CSO) – An office of the department that administers social and health services at the community level. [WAC 388-500-0005]

Core provider agreement – The basic contract that MAA holds with providers serving MAA clients. The provider agreement outlines and defines terms of participation in Medical Assistance.

Covered service – A service that is within the scope of the eligible client’s medical care program, subject to the limitations in Chapter 388-531 WAC and other published WAC.

Current procedural terminology (CPT™) – A systematic listing of descriptive terms and identifying codes for reporting medical services, procedures, and interventions performed by physicians and other practitioners who provide physician-related services. CPT is copyrighted and published annually by the American Medical Association.

Department – The state Department of Social and Health Services
[WAC 388-500-0005]

Early and periodic screening, diagnosis, and treatment (EPSDT) – Formerly known as the “Healthy Kids” program, means a program providing early periodic screening, diagnosis and treatment to persons younger than 21 years of age who are eligible for Medicaid.
[Refer to WAC 388-500-0005]

EPSDT provider – (1) A physician, advanced registered nurse practitioner (ARNP), or public health nurse certified as an EPSDT provider; *or* (2) a dentist, dental hygienist, audiologist, or optometrist who is an enrolled Medical Assistance provider and performs all or one component of the EPSDT screening.

Explanation of benefits (EOB) – A coded message on the Medical Assistance Remittance and Status Report that gives detailed information about the claim associated with that report.

Explanation of Medicare benefits (EOMB) – A federal report generated for Medicare providers displaying transaction information regarding Medicare claims processing and payments.

Expedited prior authorization (EPA) – A process designed by MAA to eliminate the need for written prior authorization (see definition for “prior authorization”). MAA establishes authorization criteria and identifies the criteria with specific codes. If the provider determines the client meets the criteria, the provider creates the authorization number using the specific MAA-established codes.

Fee-for-service – The general payment method MAA uses to reimburse providers for covered medical services provided to medical assistance clients when those services are not covered under MAA’s Managed Care plans or State Children’s Health Insurance Program (SCHIP).

Informed consent – Where an individual consents to a procedure after the provider who obtained a properly completed consent form has done all of the following:

- (1) Disclosed and discussed the client's diagnosis; and
- (2) Offered the client an opportunity to ask questions about the procedure and to request information in writing; and
- (3) Given the client a copy of the consent form; and
- (4) Communicated effectively using any language interpretation or special communication device necessary per 42 C.F.R. Chapter IV 441.257; and
- (5) Given the client oral information about all of the following:
 - (a) The client's right to not obtain the procedure, including potential risks, benefits, and the consequences of not obtaining the procedure; and
 - (b) Alternatives to the procedure including potential risks, benefits, and consequences; and
 - (c) The procedure itself, including potential risks, benefits, and consequences.

Inpatient hospital admission – An admission to a hospital that is limited to medically necessary care based on an evaluation of the client using objective clinical indicators, assessment, monitoring, and therapeutic service required to best manage the client's illness or injury, and that is documented in the client's medical record.

Limitation extension – A process for requesting and approving reimbursement for covered services whose proposed quantity, frequency, or intensity exceeds that which MAA routinely reimburses. Limitation extensions require prior authorization.

Managed care – A prepaid comprehensive system of medical and health care delivery including preventive, primary, specialty, and ancillary health services.
[WAC 388-538-050]

Maximum allowable fee – The maximum dollar amount that MAA reimburses a provider for specific services, supplies, and equipment.

Medical assistance administration (MAA) – The administration within DSHS authorized by the secretary to administer the acute care portion of the Title XIX Medicaid, Title XXI Children's Health Insurance Program (SCHIP), and the state-funded medical care programs, with the exception of certain non-medical services for persons with chronic disabilities.

Medicaid – The state and federally funded aid program that covers the Categorically Needy (CNP) and Medically Needy (MNP) programs.

Medical consultant – Physicians employed by MAA who are authorities on the medical aspects of the Medical Assistance program. As part of their responsibilities, MAA medical consultants:

- Serve as advisors in communicating to the medical community the scope, limit, and purpose of the program.
- Assist in the development of MAA medical policy, procedures, guidelines, and protocols.
- Evaluate the appropriateness and medical necessity of proposed or requested medical treatments in accordance with federal and state law, applicable regulations, MAA policy, and community standards of medical care.
- Serve as advisors to MAA staff, helping them to relate medical practice realities to activities such as claims processing, legislative requests, cost containment, and utilization management.
- Serve as liaisons between MAA and various professional provider groups, health care systems (such as HMOs), and other State agencies.
- Serve as expert medical and program policy witnesses for MAA at fair hearings.

Medical identification card – The form DSHS uses to identify clients of medical programs. These cards are good only for the dates printed on them. Clients will receive a Medical Identification card in the mail each month they are eligible. These cards are also known as DSHS Medical ID cards and were formerly called medical coupons or MAID cards.

Medically necessary – A term for describing a requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent worsening of conditions in the client that endanger life, or cause suffering or pain, or result in an illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction. There is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the client requesting the service. For the purpose of this section, “course of treatment” may include mere observation or, where appropriate, no treatment at all. [WAC 388-500-0005]

Medicare – The federal government health insurance program for certain aged or disabled clients under Titles II and XVIII of the Social Security Act. Medicare has two parts:

- “Part A” covers the Medicare inpatient hospital, post-hospital skilled nursing facility care, home health services, and hospice care.
- “Part B” is the supplementary medical insurance benefit (SMIB) covering the Medicare doctor’s services, outpatient hospital care, outpatient physical therapy and speech pathology services, home health care, and other health services and supplies not covered under Part A of Medicare. [WAC 388-500-0005]

Newborn – To assist providers in billing CPT codes with “newborn” in the description, MAA defines newborns as younger than 1 year of age.

Noncovered service or charge – A service or charge not reimbursed by the department.

Patient identification code (PIC) – An alphanumeric code that is assigned to each Medical Assistance client and which consists of:

- First and middle initials (or a dash (-) must be entered if the middle initial is not indicated).
- Six-digit birth date, consisting of numerals only (MMDDYY).
- First five letters of the last name (and spaces if the name is fewer than five letters).
- Alpha or numeric character (tiebreaker).

Pound indicator (#) – A symbol (#) indicating a procedure code listed in MAA's fee schedules that is not covered.

Prior authorization – Written MAA approval for certain medical services, equipment, or supplies, before the services are provided to clients, as a precondition for provider reimbursement. *Expedited prior authorization and limitation extensions are forms of prior authorization.*

Professional component – The part of a procedure or service that relies on the provider's professional skill or training, or the part of that reimbursement that recognizes the provider's cognitive skill.

Provider or provider of service – An institution, agency, or person:

- Who has a signed agreement (Core Provider Agreement) with the department to furnish medical care, goods, and/or services to clients; and
- Is eligible to receive payment from the department. [WAC 388-500-0005]

Relative value unit (RVU) – A unit that is based on the resources required to perform an individual service. RBRVS RVUs are comprised of three components – physician work, practice expense, and malpractice expense.

Remittance and status report (RA) – A report produced by MAA's claims processing system (known as the Medicaid Management Information System or MMIS) that provides detailed information concerning submitted claims and other financial transactions.

Resource based relative value scale (RBRVS) – A scale that measures the relative value of a medical service or intervention, based on the amount of physician resources involved.

RBRVS maximum allowable amount – The Medicare Fee Schedule relative value unit, multiplied by the statewide geographic practice cost index, times the applicable conversion factor.

Revised code of Washington (RCW) – Washington State laws.

Technical component – The part of a procedure or service that relates to the equipment set-up and technician's time, or the part of the procedure and service reimbursement that recognizes the equipment cost and technician time.

Third party – Any entity that is or may be liable to pay all or part of the medical cost of care of a federal Medicaid or state medical program client. [WAC 388-500-0005]

Title XIX – The portion of the federal Social Security Act that authorizes grants to states for medical assistance programs. Title XIX is also called Medicaid.
[WAC 388-500-0005]

Usual and customary fee – The rate that may be billed to the Department for a certain service or equipment. This rate may not exceed:

- 1) The usual and customary charge billed to the general public for the same services;
or
- 2) If the general public is not served, the rate normally offered to other contractors for the same services.

Washington administrative code (WAC)
– Codified rules of the State of Washington.